

SUBCOMMITTEE NO. 3

Agenda

Health, Human Services, Labor & Veteran's Affairs

Chair, Senator Elaine K. Alquist

**Senator Alex Padilla
Senator Dave Cogdill**



March 26, 2006

1:00 PM

**Room 2040
(John L. Burton Hearing Room)**

(Diane Van Maren)

<u>Item</u>	<u>Department</u>
4280	Managed Risk Medical Insurance Board <ul style="list-style-type: none">• Managed Risk Medical Insurance Program• Healthy Families Program
4260	Department of Health Care Services <ul style="list-style-type: none">• Medi-Cal Program (Selected Issues)
4265	Department of Public Health <ul style="list-style-type: none">• SB 437 implementation• Other programs as noted which interact with Medi-Cal

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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Managed Risk Medical Insurance Board (MRMIB)

A. OVERALL BACKGROUND (Page 2 through Page 5)

Purpose and Description of Department. The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. **The MRMIB administers the: (1)** Healthy Families Program; **(2)** Access for Infants and Mothers (AIM) Program; and **(3)** Major Risk Medical Insurance Program (MRMIP).

Summary of Funding. The budget proposes total expenditures of almost \$1.3 billion (\$394.7 million General Fund, \$776.5 million Federal Trust Fund and \$111.1 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. This funding level represents a net increase of \$82.5 million (\$32.6 million General Fund) over the revised current-year. The net increase is due to changes in the Healthy Families Program and Access for Infants and Mothers (AIM) Program as discussed below.

Summary of Expenditures				
(dollars in thousands)	2006-07	2007-08	\$ Change	% Change
Program Source				
Healthy Families Program (including state support)	\$1,023,688	\$1,099,685	\$75,997	7.4
Major Risk Medical Insurance (including state support)	\$44,652	\$39,808	-\$4,844	10.8
Access for Infants & Mother (including state support)	\$128,403	\$139,677	\$11,274	8.8
County Health Initiative Program	\$3,061	\$3,168	107	3.5
Totals Expenditures	\$1,199,804	\$1,282,338	\$82,534	6.9
Fund Sources				
General Fund	\$362,020	\$394,669	\$32,649	9.0
Federal Funds	\$717,402	\$776,529	\$59,127	8.2
Other Funds	\$120,382	\$111,140	-\$9,242	7.7
Total Funds	\$1,199,804	\$1,282,338	\$82,534	6.9

(Overall Background continued)

Overall Background—Description of the Healthy Families Program. The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to children (up to age 19) in families with incomes up to 250 percent of the federal poverty level, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until at least the age of two. If these AIM to HFP two-year olds are in families that exceed the 250 percent federal income level, then they are no longer eligible to remain in the HFP.

There are also two “bridge” programs that enable children to transition from Medi-Cal to the HFP, and from the HFP to Medi-Cal. This is done in order to help ensure continued coverage for children who may be going back and forth between the two programs due to family income changes, or a change in their age. It should be noted that with the enactment of Senate Bill 437 (Escutia), Statutes of 2006, the “bridge” programs will phase-out and presumptive eligibility processes will be implemented.

Summary of Eligibility for the Healthy Families Program (HFP) (See Chart in Hand Out)

Type of Enrollee in the HFP	Income Level Based on Federal Poverty	Comments
Infants up to the age of two years who are born to women enrolled in Access for Infants & Mothers (AIM).	200 % to 300 %	If income from 200% to 250%, covered through age 18. If income is above 250 %, they are covered up to age 2.
Children ages one through 5 years	133 % to 250 %	Healthy Families Program covers above 133 percent because children below this are eligible for Medi-Cal.
Children ages 6 through 18 years	100 % to 250 %	Healthy Families Program covers children in families above 100 %. Families with two children may be “split” between programs due to age.
Some children enrolled in County “Healthy Kids” programs. These include (1) children without residency documentation; and (2) children from 250 percent to 300 percent of poverty.	Not eligible for Healthy Families Program, including 250 percent to 300 percent	State provides federal S-CHIP funds to county projects as approved by the <i>MRMIB</i> . Counties provide the match for the federal funds.

(Overall Background continued)

Background—HFP Benefit Package. The HFP benefit package is modeled after that offered to state employees, including health, dental and vision. The enabling federal legislation—the State’s Children’s Health Insurance Program (S-CHIP)—required states to use this “benchmark” approach. These benefits are provided through managed care arrangements. The HFP directly contracts with participating health, dental and vision care plans. Participation from these plans varies across the state but consumer choice has always been available.

In addition to these HFP benefits, enrolled children can also access the California Children’s Services (CCS) Program if they have a CCS-eligible medical condition. An HFP enrolled child is also eligible to receive *supplemental* mental health services provided through County Mental Health Plans. These additional services are provided in accordance with state statute that created California’s Healthy Families Program (i.e., California’s S-CHIP). These services are also available to children enrolled in Medi-Cal.

Background—HFP Premiums. Families pay a monthly premium and copayments, as applicable. The amount paid varies according to a family’s income and the health plan selected. Families below 200 percent of poverty pay premiums ranging from \$4 to \$9 per child per month, up to a family maximum of \$27 per month. Families that select a health plan designated as a “community provider plan” receive a \$3 discount per child on their monthly premiums. Families with incomes between 200 percent and 250 percent of poverty pay \$12 to \$15 per child per month. The family maximum per month is \$45 for these families.

Summary of Budget Year Funding and Enrollment for the HFP. A total of \$1.1 billion (\$392.2 million General Fund, \$689.5 million Federal Title XXI Funds, \$2.2 million Proposition 99 Funds, and \$6.4 million in reimbursements) is proposed for the HFP, excluding state administration. **This reflects an increase of \$75.8 million (\$32.5 million General Fund), or 9 percent over the revised current-year. Most of this increase is attributable to caseload increases.**

The budget assumes a total enrollment of 915,598 children as of June 30, 2008, an increase of 73,870 children over the revised current year enrollment level, or a growth rate of 8.8 percent.

This projected enrollment level reflects growth primarily attributable to: **(1)** restoration of the Certified Application Assistance Program and related outreach and enrollment changes contained in the Budget Act of 2006; and **(2)** implementation of Senate Bill 437 (Escutia), Statutes of 2006, which provides for a self-certification process at annual eligibility review.

(Overall Background continued)

Total HFP enrollment of **915,598 children** is summarized by population segment below:

- Children in families up to 200 percent of poverty 607,818 children
- Children in families between 201 to 250 percent of poverty 193,177 children
- Children in families who are legal immigrants 15,810 children
- Access for Infants and Mothers (AIM)-Linked Infants 16,476 children
- New children due to changes in Certified Application Assistance 21,908 children
- New children due to various modifications in the enrollment process 47,173 children
- New children due to implementation of SB 437, Statutes of 2006 13,237 children

(The “Vote Only” Calendar begins on the next page)

B. ISSUES FOR “VOTE ONLY” (Items 1 and 2, through Page 8)

1. Change Administrative Oversight of Managed Risk Medical Insurance Program

Issue. The Board proposes to redirect \$698,000 (Medical Risk Insurance Fund) from the Managed Risk Medical Insurance Program (MRMIP) to state support to fund two Research Program Specialist positions (two-year limited-term) and enact certain administrative changes. Of the \$698,000 to be redirected, \$263,000 is one-time only (i.e., \$435,000 would be ongoing at least for two years).

The Board states that this proposed redirection over time will lead to program savings that will offset the loss of funding for direct services.

The Board contracts with an “Administrative Vendor” to handle the day-to-day administrative functions of the MRMIP, including eligibility determinations, enrollment transactions and premium processing. Program oversight is provided by the Board’s staff in consultation with contracted actuarial consultants. Board staff are also responsible for payments to health plans, the processing of administrative vendor invoices, and the annual reconciliation of claims and payment data.

First, the Board has identified several program enhancements and efficiencies that would be made. **The budget proposal includes \$500,000 (Managed Risk Medical Insurance Fund) for the Administrative Vendor contractor to make these program enhancements and efficiencies.** These include the following activities:

- Increasing coordination of eligibility and financial requirements;
- Increasing the available payment mechanisms for making subscriber payments;
- Improving the toll-free telephone line service;
- Creating an independent audit function;
- Performing plan enrollment reconciliation;
- Enhancing the administrative follow-up on incomplete applications;
- Translating materials into Spanish; and
- Creating on-line access to the MRMIP system for Board staff;

Second, two Research Program Specialist positions would be hired on a two-year limited-term basis. The staff is to be hired by September 2007 and will focus on the reprocurement of the administrative vendor contract.

One of the positions would be used to perform various administrative vendor oversight functions, including the design and development of upgraded services, the development of contract amendments and business rules, the testing of changes, and the monitoring of the upgrades.

The second position would design and develop financial and data management improvements to be incorporated into health plan contracts and used in monthly payment and annual reconciliation processes to improve fiscal accountability. These improvements would include performing enrollment reconciliations between the administrative vendor records and plan payments in order to identify billing issues and assure prevention of over-billing, reviewing quarterly claims data to monitor loss ratios and assess plan performance, and working with organizations to identify best practices.

Background—What is the MRMIP? The Board administers the Major Risk Medical Insurance Program (MRMIP) which provides health care coverage to medically high-risk individuals as well as individuals who have been refused coverage through the health insurance market. The program was established in 1991 and has been funded using special fund moneys as described below. **The budget proposes total expenditures of about \$40 million (Major Risk Medical Insurance Fund) to serve about 8,700 individuals.**

The benefit and administrative costs for MRMIP are funded by subscriber premiums combined with a capped annual subsidy of \$40 million in Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds) which are deposited into the Major Risk Medical Insurance Fund. The program has been capped at the \$40 million for many years; however the subscriber premiums usually provide an additional \$27 to \$29 million annually toward the program. The subscriber premiums go directly to the plans to offset their total costs for providing the benefits.

The Board contracts with an “administrative vendor” to handle the day-to-day administrative functions of the MRMIP, including eligibility determinations, enrollment transactions, and premium processing. Program oversight is provided by the Board’s staff in consultation with contracted actuarial consultants. Board staff are also responsible for payments to health plans, the processing of administrative vendor invoices, and the annual reconciliation of claims and payment data.

Subcommittee Staff Recommendation--Approve. Though it is usually *not* desirable to redirect funds from direct services to administrative functions, it is recommended to approve the Board’s proposal as requested. The proposed enhancements and efficiencies are needed and the Board’s approach seems reasonable.

The MRMIP has historically kept its administrative costs to a minimum. For example, the administrative expenditures in 2004-05 were less than 3 percent. Therefore, this adjustment is *not* being added to any large administrative cost base.

In addition, with the two positions being limited-term (two years), the Legislature will have with another opportunity to revisit the issue.

2. Access for Infants and Mothers (AIM) Program—Program Estimate

Issue. A total of \$138.7 million (\$60.7 million Perinatal Insurance Fund and \$78 million federal funds) is proposed for AIM in 2007-08. This funding level reflects an increase of \$11.2 million (total funds) over the revised current-year.

MRMIB states that the increase is due to caseload increases as well as an overall increase in the capitation payment made to health plans (from \$9,530 per woman per month to \$9,541 per woman per month). The overall increase paid to health plans reflects a change in the distribution of AIM mothers to more slightly more costly plans (i.e., MRMIB negotiates rates separately with each plan and AIM mothers select a plan). No changes to the development of the fiscal calculations are proposed. A total of 13,912 women are expected to utilize AIM.

Additional Background Information. The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus \$100 for the infant's second year of coverage.

As of July 1, 2004, infants born to AIM women are automatically enrolled in the Healthy Families Program (HFP) at birth. Infants born during 2004-05 to AIM mothers who enrolled in AIM prior to July 1, 2005 will remain in AIM through two years of age. Therefore, infant enrollment is declining and shifting to the HFP. This is because infants will age out of the AIM Program at two years old while no new infants will be enrolled after July 1, 2004, unless the AIM mother was enrolled prior to that date. Therefore, the AIM Program is transitioning to focusing only on pregnant women and 60-day post partum health care coverage.

Subcommittee Staff Recommendation--Approve. It is recommended to approve this baseline budget pending receipt of the Governor's May Revision. The Governor's May Revision will likely reflect minor adjustments to caseload. No issues have been raised.

C. ISSUES FOR DISCUSSION--Healthy Families & Children's Medi-Cal

1. Healthy Families Program-- Update on Federal Funding and Its Reauthorization

Issue. The federal "State Children's Health Insurance Program (S-CHIP), known in California as the Healthy Families Program (HFP), **must be reauthorized by the federal government by September 2007 or additional federal funds will *not* be available for expenditure.** If additional federal funds are not available to California, the HFP and related services to children will be at significant risk for reduction and potentially tens of thousands of children would go without health care coverage.

The federal government provides states with an "allotment" of funding that is capped. The matching percentage for California is 65 percent. Historically, California has received 16 percent of the overall federal appropriation for S-CHIP funding. It should be noted that the S-CHIP matching percentage of 65 percent is higher than what California receives for Medi-Cal (only 50 percent).

California operates the largest program in the nation. We use federal S-CHIP funds to support children's programs in several areas, including the HFP (the majority of the funding), as well as certain expansions for children contained within the Medi-Cal Program, such as waiving the assets test and limited presumptive eligibility while applications are being process (such as when changing between programs).

The President's proposed budget for federal fiscal year 2008 (which commences October 1, 2007) fails to provide sufficient funding for the federal S-CHIP to sustain many state's programs, including California's. In addition, the President's proposal would limit federal S-CHIP funding to states to only cover children in families with incomes at 200 percent or below the federal poverty level. Our Healthy Families Program covers up to 250 percent of poverty, as well as infants born to women enrolled in the Access for Infants and Mothers (AIM) Program as discussed below (i.e., 300 percent of poverty).

Congress is presently discussing the reauthorization but has thus far only focused on concerns regarding the current federal fiscal year. Fourteen states are projected to exhaust their S-CHIP grants in the current year and efforts are underway to redistribute funds to provide assistance to them. (California is not one of these states.) Discussions regarding the federal budget year (commencing October 1, 2007) have not yet begun in earnest.

For the first many years of implementation, California was not fully expending its annual federal S-CHIP allotment. As such, unexpended federal fund allotments were rolled forward to be expended in subsequent years (unspent funds can be rolled forward for up to three years). **However since federal fiscal year 2003, California has been exceeding each year's federal allotment and has been relying on unspent federal funds from prior years to bridge the gap between expenditures and federal allotments.**

Based on an analysis requested by the MRMIB and funded by the California Healthcare Foundation (released on March 7, 2007), **California would need a total of between \$6.7 billion and \$8.1 billion in federal S-CHIP funds over the next five years to meet and sustain *current* programs funded by the federal S-CHIP funds, including the HFP as well as other services provided to children within Medi-Cal as referenced above.** In other words, California would need to receive at least \$1.3 billion to \$1.6 billion in federal S-CHIP funds annually to continue our existing services to children, assuming continued caseload adjustments and certain cost factors.

Subcommittee Staff Comment—MRMIB Report Back At May Revision. For California to sustain coverage for children in families with incomes up to 250 percent of poverty in the HFP, as well as the other services, we will need to receive about double the amount of federal funding we are presently receiving. Under the President's proposed budget, about 248,000 children currently enrolled in the HFP would be dropped from enrollment due to the lack of federal S-CHIP funding. As such, it will be up to Congress to provide a higher level of reauthorization funding.

The Legislature has communicated the importance of this issue to Senators Feinstein and Boxer, as well as other members of the California delegation.

It is recommended to have the MRMIB report back at the May Revision on the status of federal S-CHIP funding.

Questions. The Subcommittee has requested the MRMIB to respond to the following questions:

1. MRMIB, Please provide an update regarding the reauthorization of federal S-CHIP funding, including both the perspective of the President's budget as well as discussions within Congress.
2. MRMIB, When may we know of the funding level? What contingencies, if any, does the Administration have in the event California cannot receive appropriate funding?
3. MRMIB, if California did not receive any additional funds, how long could we sustain our existing program (i.e., when might we fully expend our existing federal match)?

2. Outreach Funding for Healthy Families Program & Medi-Cal Program

Issues. First, the Administration proposes to continue several strategies to improve the enrollment of uninsured, eligible children into Medi-Cal and the HFP. These strategies and the proposed increases are shown in the table below. A description of each of these strategies is outlined in the background section below.

A total increase of \$13.1 million (\$5.6 million GF) is proposed for the budget year as shown in the table below.

Table: Expenditures for Outreach Strategies to Enroll More Children in Programs

Outreach Strategy	Healthy Families	Medi-Cal	Total Amount	Increase Over 2006-07
County Allocations	N/A	\$29.7 million (\$12.9 million GF)	\$29.7 million (\$12.9 million GF)	\$10 million (\$4.4 million GF)
Certified Application Assistance Fees	\$7.9 million (\$3.5 million GF)	\$1.2 million (federal funds only)	\$9.1 million (\$3.5 million GF)	\$2.9 million (\$1.1 million GF)
Toll Free Line		\$1.8 million (\$900,000 GF)	\$1.8 million (\$900,000 GF)	\$250,000 (\$125,000 GF)
Total for Strategies	\$7.9 million	\$32.7 million	\$40.6 million	\$13.1 million (\$5.6 million GF)

Second, the budget provides increased funding for the HFP and Medi-Cal programs for anticipated increases in caseload which are attributable to the above outreach strategies, as well as to several eligibility enrollment forms and processes that were changed last year.

The table below displays this caseload and funding information. It should be noted that the Administration cannot *directly* track outreach expenditures to caseload increases for every strategy, particularly those related to the Medi-Cal Program.

Table: Estimated Caseload and Funding Associate with Outreach Strategies

Reason/Strategy	Caseload Adjustments for Healthy Families	Caseload Adjustments for Medi-Cal	Total Dollars & Caseload	Increase Over 2006-07
Simplified Redetermination Forms in Medi-Cal Program	N/A	\$73.9 million (\$36.9 million GF) 30,436 caseload	\$73.9 million (\$36.9 million GF) 30,436 caseload	\$29 million (\$14.5 million GF) 11,957 caseload
Streamlined Enrollment for the HFP (Initial Application & "Health-e-App" electronic submittal process)	\$34.6 million (\$12.6 million GF) 49,235 caseload	N/A	\$34.6 million (\$12.6 million GF) 49,235 caseload	\$25.1 million (\$9.1 million GF)
Certified Application Assistance Impact	\$10.4 million (\$3.8 million GF) 19,846 caseload	Not Identified	\$10.4 million (\$3.8 million GF) 19,846 caseload	\$3.5 million (\$1.3 million)

Background—What Are the County Allocations? Through the Budget Act of 2006, a total of \$19.7 million (total funds) was appropriated to the DHS to establish a county outreach allocation program. Priority for this funding was provided to twenty large counties, with almost \$3 million being made available to small, rural counties. Each county must submit a plan to the DHS in order to receive their allocation funds.

It should be noted that the DHS only recently authorized in February for counties to commence with their plans; therefore, it is unlikely that the current-year allocations will be fully expended. In addition, the county allocations will be paid in arrears—i.e., the counties will spend the funds and the state will reimburse the expenditure.

Table 1—Large Counties (County Allocation)

Large County	2006-07 Allocation	2007-08 Allocation	2008-09 Allocation	Total
Los Angeles	\$6,140,508	\$9,820,764	\$9,820,764	\$25,782,036
Orange	\$1,408,350	\$2,252,431	\$2,252,431	\$5,913,212
San Diego	\$1,406,506	\$2,249,482	\$2,249,482	\$5,905,470
San Bernardino	\$1,262,191	\$2,018,675	\$2,018,675	\$5,299,541
Riverside	\$1,099,788	\$1,758,935	\$1,758,935	\$4,617,658
Fresno	\$661,242	\$1,057,551	\$1,057,551	\$2,776,344
Sacramento	\$649,302	\$1,038,454	\$1,038,454	\$2,726,210
Alameda	\$514,328	\$822,586	\$822,586	\$2,159,500
Kern	\$493,188	\$788,776	\$788,776	\$2,070,740
Santa Clara	\$465,537	\$744,552	\$744,552	\$1,954,641
San Joaquin	\$372,152	\$595,198	\$595,198	\$1,562,548
Tulare	\$342,638	\$547,995	\$547,995	\$1,438,628
Stanislaus	\$286,193	\$457,721	\$457,721	\$1,201,635
Ventura	\$284,685	\$455,308	\$455,308	\$1,195,301
Monterey	\$248,695	\$397,747	\$397,747	\$1,044,189
Contra Costa	\$230,572	\$368,763	\$368,763	\$968,098
Santa Barbara	\$226,983	\$363,024	\$363,024	\$953,031
Merced	\$210,309	\$336,356	\$336,356	\$883,021
San Mateo	\$201,335	\$322,004	\$322,004	\$845,343
San Francisco	\$180,498	\$288,678	\$288,678	\$757,854
Total	\$16,685,000	\$26,685,000	\$26,685,000	\$70,055,000

Table 2—Small Counties (County Allocation)

Small County	2006-07 Allocation	2007-08 Allocation	2008-09 Allocation	Total
Del Norte	\$194,790	\$96,258	\$89,611	\$380,659
El Dorado	\$265,315	\$288,000	\$288,000	\$841,315
Humboldt	\$258,480	\$258,480	\$258,480	\$775,440
Kings	\$268,279	\$268,279	\$268,279	\$804,837
Marin	\$175,868	\$282,262	\$262,771	\$720,901
Mendocino	\$229,561	\$236,301	\$235,231	\$701,093
Napa	\$288,000	\$288,000	\$288,000	\$864,000
San Luis Obispo	\$254,943	\$219,812	\$226,007	\$700,762
Santa Cruz	\$192,000	\$288,000	\$288,000	\$768,000
Solano	\$194,051	\$201,917	\$219,624	\$615,592
Sonoma	\$212,100	\$284,691	\$287,997	\$784,788
Yolo	\$288,000	\$288,000	\$288,000	\$864,000
Total	\$2,821,387	\$3,000,000	\$3,000,000	\$8,821,387

Background—What Is the Certified Application Assistance (CAA) Process? Under the CAA process, trained and certified assistors facilitate the enrollment of eligible children and their families into the HFP or Medi-Cal Program. The assistors receive a payment (i.e., fee) as follows for success enrollments: (1) \$50 fee for initial enrollment; (2) \$50 fee for annual redeterminations; and (3) \$60 fee for initial enrollment and annual redeterminations that utilize the electronic “Health-e-App” web-based application. According to the Administration, the CAA process is a time-tested method that has proven effective in ensuring that HFP and Medi-Cal eligible children applicants are successful in enrolling and remaining in the programs.

Subcommittee Staff Recommendation--Approve. The outreach strategies have proven to be effective in enrolling eligible children and when applicable their families. Approximately 428,000 children are eligible for Medi-Cal or the HFP but are not yet enrolled. As such, there is a clear need to continue outreach efforts.

Though it is unlikely that current-year funds will be fully expended for the county allocations, it is recommended at this time to precede with the budget year allocations at the level proposed by the Administration. The May Revision will likely have some minor adjustments to reflect updated caseload impacts. These adjustments can be discussed at that time.

Finally, it is important for the Legislature to maintain its oversight of these outreach strategies to ensure they are reaching diverse communities and are achieving tangible enrollment and retention results.

Questions. The Subcommittee has requested the Administration (DHS/MRMIB) to respond to the following questions.

1. DHCS, Please provide an update on the County Allocation process. What are some key outreach strategies counties will be using and how will reimbursement to the counties flow?
2. Administration, how are the MRMIB and DHCS coordinating the outreach strategies between programs where applicable?
3. MRMIB, When will the “Health-e-App” web-based application be fully public and accessible as proposed through the actions taken in the Budget Act of 2006?

3. Implementation of Senate Bill 437, Statutes of 2006--Local Assistance Piece

Issue. The budget proposes several adjustments related to local assistance funding with the Healthy Families Program (HFP) and Medi-Cal Program for the implementation of Senate Bill 437 (Escutia), Statutes of 2006. **The total proposed increase for local assistance functions is \$34.7 million (\$16.4 million General Fund, \$14.2 million federal Medicaid funds, and \$2.2 million federal S-CHIP funds).**

SB 437, Statutes of 2006, creates processes to reduce program complexities for the approximately 428,000 children who are eligible for Medi-Cal or the HFP but are not enrolled, by allowing simplified and expedited access to health benefits. (The key aspects of the legislation are discussed in this Agenda under the background section below.)

The following tables display the amounts contained in the budget for each program and related SB 437 component. (The state support costs for SB 437 are discussed in this Agenda under item 4 below.)

Local Assistance: Medi-Cal Program Adjustments for SB 437 for 2007-08 (DHCS)

SB 437 Component	Description	Total Funds	General Fund
Self Certification: Caseload	Two county Pilot for two-years allowing applicants and enrollees to self-certify income and assets. Assumes a 16,472 caseload per month and a July 1 start date.	\$20.7 million	\$10.3 million
Self Certification: County Administration	County administrative costs for cases added due to self certification pilot.	\$6.9 million	\$3.5 million
Self Certification: Evaluation	Expenditures for development of the evaluation of the pilots. UCSF will be conducting the evaluation.	\$525,000	\$263,000
WIC Gateway & Changes to Presumptive Eligibility	Contracts for the "feasibility study report" and data processing guidance for systems changes to implement the WIC gateway, HFP presumptive eligibility and Medi-Cal to HFP presumptive eligibility.	\$418,000	\$176,000
Total for department		\$28.6 million	\$14.2 million

Local Assistance: Healthy Families Program Costs for SB 437 for 2007-08 (MRMIB)

SB 437 Component	Description	Total Funds	General Fund
Self Certification: Caseload	HFP enrollment will begin January 1, 2008 for the entire program. Assumes six months of enrollment and an increase of 13,237 children.	\$5.5 million	\$2 million
Administrative Changes	One-time costs for "Administrative Vendor" changes to be done within the HFP	\$600,000	\$210,000
Total for MRMIB		\$6.1 million	\$2.2 million

The Administration states that Orange County has been selected to be one of the Pilot counties for Medi-Cal self-certification and the second county is still as yet undetermined. They do anticipate selecting a county soon, prior to July 1st.

It should also be noted that the Administration is presently unclear as to whether “feasibility study reports” are needed for the DHCS to proceed with the two presumptive eligibility components as well as the WIC gateway. As such, these costs may not fully materialize.

Background—Description of Senate Bill 437 (Escutia), Statutes of 2006. This legislation includes strategies to promote and maximize enrollment in the Medi-Cal Program and the HFP, improve the retention of children already enrolled, and strengthen county-based efforts to enroll eligible children in existing public programs. These strategies include the following:

- Self Certification for the HFP. The MRMIB is required to implement processes by which applicants at the time of annual eligibility review may self-certify income rather than provide income documentation. The MRMIB will establish rules concerning which applicants will be permitted to certify income and the circumstances in which supplemental information may be required by January 2008.
- Self Certification for the Medi-Cal Program. The Department of Health Care Services is required to implement a process that allows applicants and enrollees of certain categories of eligibility to self-certify income and assets. This process is to be implemented in two phases. The first phase is a two-year Pilot project to be operated in two counties. **Orange County has been selected to be a pilot and the second county is still pending.** After an evaluation of the Pilot, a statewide rollout can be conducted.
- Healthy Families Presumptive Eligibility. This program will replace the existing bridge for Medi-Cal to the HFP and will provide benefits until the HFP eligibility determination has been completed. This new presumptive eligibility process will require an automated/electronic process between the Department of Health Care Services, the MRMIB, and the Department of Public Health. As such, a “feasibility study report” will be required. (These are analyses conducted for all automated/electronic/information processing systems.)
- Medi-Cal to HFP Presumptive Eligibility. This program will replace the existing Medi-Cal to HFP accelerated enrollment process by implementing a presumptive eligibility program to provide children screened at Medi-Cal application that meet certain criteria with continuous no cost health care benefits until the child’s final eligibility is determined under the HFP.
- Women, Infant and Children Supplemental Food Program (WIC) Gateway. The Department of Health Care Services, the MRMIB and the Department of Public Health are required to design, promulgate, and implement policies and procedures for an automated enrollment gateway system. This system will provide presumptive eligibility to qualifying low-income children until a final eligibility determination could be made for enrollment into the Medi-Cal Program or the HFP.

The table below provides more of a description of each of these strategies and their application.

Description of Each Strategy Under Senate Bill 437 (Escutia), Statutes of 2006

	Self Certification Of Income & Assets	HFP Presumptive Eligibility	Medi-Cal to HFP Presumptive Eligibility	WIC Gateway (Automatic Application)
Description	Elimination of verification of income and property (Pilot).	Provides full-scope coverage until HFP eligibility is determined.	Full-scope coverage until HFP eligibility determined.	Automatic full-scope coverage until Medi-Cal or HFP eligibility determined.
Persons Impacted	Children and families in Medi-Cal	Children enrolled in Medi-Cal who become ineligible due to property or are determined to have a “share-of-cost”.	Any child who goes to County and requests Medi-Cal or HFP, after screening for income within HFP limits.	WIC applicants
Implementation Date	July 2007	After “feasibility study report” approval, federal approval and system development.	After “feasibility study report” approval, federal approval and system development.	After “feasibility study report” approval, federal approval and system development.
Expiration Date	Pilot expires as of June, 2009. Statewide implementation based on outcomes from Pilot.	None.	Three years after implementation.	
Funding Sources	General Fund and federal Medicaid	General Fund and federal S-CHIP	General Fund and federal S-CHIP	General Fund and federal S-CHIP

Legislative Analyst’s Office Recommendation—Reduce County Administration. The LAO believes the Administration has over estimated the increased amount for the county administrative processing costs. Specifically, they believe a reduction of \$5.4 million (\$2.7 million General Fund) should be made to account for savings likely to occur from the reduced processing time per eligibility application with the self-certification pilot.

Subcommittee Staff Recommendation—Concur with LAO Recommendation. It is recommended to adopt the LAO recommendation. The DHCS over estimated their calculation.

Questions. The Subcommittee has requested the Administration to respond to the following questions.

1. DHCS and MRMIB, Please provide a brief summary of SB 437, using the tables provided in the agenda, and the proposed budget request.
2. Administration, Please clarify how many “feasibility study reports” are needed for the

information technology changes required by SB 437, and whether the proposed budgeted amount for this can be modified.

4. Implementation of Senate Bill 437, Statutes of 2006—State Support Piece

Issue. The budget proposes a total increase of 10 state positions across three areas, including the MRMIB, the Department of Health Care Services (DHCS) and the Department of Public Health (DPH), to implement the components of Senate Bill 437 (Escutia), Statutes of 2006. **The total request for state support is \$1.1 million (\$467,000 General Fund, \$319,000 federal Medicaid funds, and \$277,000 federal S-CHIP funds).**

- **Department of Health Care Services—3 positions.** The DHCS is requesting three Associate Governmental Program Analyst positions for total expenditures of \$294,000 (\$147,000 General Fund). All of the requested positions would be permanent.

One position would be used to conduct and evaluate the two-year Medi-Cal self-certification Pilot. Two of the positions would be used to coordinate procedural and regulatory changes, oversee systems changes to transmit the necessary data to make an HFP eligibility determination electronic, and other monitoring and evaluation activities needed to implement the two presumptive eligibility programs and the WIC gateway.

- **Department of Public Health (DPH)—3 positions.** The DPH is requesting three positions—two Staff Information Systems Analysts (Systems Analysts), and one Associate Governmental Program Analyst. The total expenditures would be \$343,000 (\$171,000 General Fund) and all of the positions would be permanent.

The two Systems Analysts will work with the DHCS, MRMIB, and contractors regarding the development and implementation phases of the WIC gateway. The Associate Governmental Program Analyst would serve as a liaison with the 82 local WIC agencies and would develop policies and training.

- **Managed Risk Medical Insurance Board (MRMIB)—4 positions.** The MRMIB is requesting four Associate Governmental Program Analysts for a total expenditure of \$426,000 (\$149,000 General Fund). All positions would be permanent.

These positions would be used to implement the HFP self certification, two presumptive eligibility programs and the WIC gateway. These staff are to coordinate procedural and regulatory changes, oversee changes needed to accept the necessary data to make an HFP eligibility determination electronically, and other monitoring, reporting and evaluation activities.

Legislative Analyst’s Office Recommendation—Delete 3 DHCS Positions. The LAO recommends deleting one position since it is *not* justified based on workload. Additionally, they believe the DHCS could *redirect* two positions from a different unit within the DHCS to fill the other two proposed positions. Therefore, the budget request would be reduced by \$294,000 (\$147,000 General Fund) if this recommendation is adopted.

Subcommittee Staff Recommendation—Modify the Administration’s Request. Due to the need for fiscal restraint, it is recommended to modify the Administration’s proposal by deleting three positions as noted below. The General Fund savings from this recommendation would be slightly less than the LAO’s due to the different federal funding ratios across programs (i.e., MRMIB receives a 65 percent S-CHIP match).

- *Department of Health Care Services Positions:* Delete one of the Associate Governmental Program Analyst (AGPA) positions as recommended by the LAO but approve the remaining two AGPA positions.
- *Department of Public Health Positions:* Approve the two Staff Information Systems Analyst positions to commence with the development of the WIC gateway, but delete the AGPA position which was to serve as a liaison with the WIC agencies. The WIC Program is well staffed overall using 100 percent federal support and can communicate and coordinate with local WIC agencies on a wide variety of issues when appropriate.
- *Managed Risk Medical Insurance Board.* Approve three of the four requested positions to implement the HFP self certification, two presumptive eligibility programs and WIC gateway. It is acknowledged that the WIC gateway will take some time to implement. As such, MRMIB will not be immediately impacted by this change.

Questions. The Subcommittee has requested the Administration to respond to the following questions.

1. Administration, Please provide a brief summary of the budget request for the 10 positions.

5. Medi-Cal Program—Family Planning Access Care & Treatment (Family PACT)

Issue. California's highly successful Family PACT Program is at significant risk due to the federal Centers for Medicare and Medicaid (CMS) reluctance to approve our Waiver renewal which is required to obtain federal matching funds for the program. The federal CMS wants significant changes made to the state's Waiver as discussed below.

This is a critical issue for it may cost California over \$300 million in lost federal funds, may require a significant increase in General Fund resources, and could significantly harm a very effective and cost-beneficial program. Using the federal government's methodology, our existing Family PACT Program generates \$2.70 in federal budget savings for every \$1 spent. The DHCS states that our existing Family PACT saves the federal government in excess of \$400 million annually.

The Schwarzenegger Administration has been negotiating with the federal CMS since Fall of 2004 to renew California's Waiver which was scheduled to expire on November 30, 2004. Since this time, California has been obtaining Waiver extensions, most recently done on a month-by-month basis. **Presently, California's Waiver has been extended to at least April 30, 2007. But it is unclear how long this extension will continue or as to when the federal CMS will formally approve California's Waiver renewal for this program.**

The federal CMS wants California to make changes to our Family PACT Program prior to approving our Waiver renewal. The Schwarzenegger Administration has agreed to make some modifications to the program to address certain federal concerns; however, other federal CMS proposed changes would *not be cost-beneficial* to the state or to the federal government and the state is pushing back on these issues. **The key proposed federal changes are as follows:**

- **1. No Federal Funds For Certain Medical Services:** The federal CMS has denied California federal matching funds provided under the Family PACT Program for the following services: mammography screening; Hepatitis B vaccines; five procedures related to complications of particular contraceptive methods; and diagnostic testing to distinguish cancer from genital warts. **The Medi-Cal Program budget does include an increase of \$2.5 million (General Fund) to backfill for the loss of federal funds for these important services.** Therefore, the services will continue at the states' cost.
- **2. Change Simple Family PACT Eligibility Process to Full Eligibility Determination.** The federal CMS wants the state to conduct *full* Medi-Cal eligibility determinations under the program. This would add a new layer of administrative cost to the program which does not now exist.

Presently, Family PACT uses a simplified eligibility process initially conducted by the provider and verified by the state. This simplified process is done to facilitate access to services and care, and to avoid the high cost of doing a full eligibility determination for a program benefit which is very limited and low cost (i.e., basically family planning services and treatment for sexually transmitted disease when applicable).

According to the Schwarzenegger Administration, it would cost the federal government, as well as the state, *more* funding to require a full eligibility determination for the Family PACT than to just continue with the simplified eligibility process and provide the services. Under the Family PACT, the average cost of a family planning benefit is \$261 annually of which 75 percent is borne by the federal government. If a full eligibility process is required as desired by the federal CMS, it would cost an *additional* \$512 (\$256 federal funds) per case for determining eligibility as done by county social services departments. **Therefore, according to DHCS calculations, it would cost hundreds of millions more in federal funds to change to a full eligibility process. In addition, a state General Fund match for these added administrative costs would also be necessary.**

This issue is still in negotiation between the Schwarzenegger Administration and the federal CMS. **If California does not prevail, an additional \$300 million or more in state General Fund support *could* be needed in order to fund the existing Family PACT program.**

- 3. Require Social Security Number for All Family PACT Enrollees. The federal CMS also wants to require California to implement a social security number requirement. California has never required a social security number for participation in the program (it is voluntary) and the Schwarzenegger Administration is opposed to this change. It is viewed as a considerable barrier to services. It should be noted that federal funds are not used to provide family planning services to nonqualified immigrants. The state solely uses General Fund support for this purpose, which is again, cost-beneficial to the state.

The Schwarzenegger Administration has presented considerable information to Secretary Leavitt, U.S. Department of Health and Human Services, and is continuing discussions with their office. Senator Feinstein and Senator Boxer have also letters in support of California's existing program.

Background—Federal Deficit Reduction Act (DRA) of 2006. Among other things, this Act requires all U.S. citizens and nationals who apply for Medicaid (Medi-Cal) to provide evidence of citizenship or national status as a condition of eligibility. Implementation of these DRA requirements is a condition of the state receiving federal funds according to the DHCS. California enacted these changes as required through AB 1807, Statutes of 2006, the Omnibus Health Trailer Bill. Generally, these changes require proof of citizenship and identity, and considerable documentation. The DHCS is in the process of implementing these various requirements.

With respect to the Family PACT Program, the federal CMS would want the full Medicaid (Medi-Cal) eligibility process to include these requirements. The Schwarzenegger Administration as well as many others, including Senator Feinstein and Senator Boxer, do not believe these requirements are applicable to the Family PACT Program and will only serve to create barriers to accessing family planning services.

Background—Existing Budget for Family PACT Program. The budget provides a total of \$462 million (\$150.5 million General Fund and \$311.6 million federal funds) for the Family PACT Program. California presently receives a 90 percent federal match for family planning services and testing services for sexually transmitted infections, and a 50 percent federal match for most other services offered under the program. The program does *not* provide pregnancy care or abortion-related services. Services provided to individuals without documentation are funded at 100 percent General Fund (about 17.79 percent of the enrollees in the program).

Overall Background on the Family PACT Program. Family PACT provides family planning services, reproductive cancer screening, and testing and treatment of sexually transmitted diseases for low-income Californians. Family PACT helps Californians plan their family size and protect their fertility. It does *not* provide pregnancy care or abortion-related services.

The intent of the program is to prevent unplanned pregnancies and the resultant financial and social welfare expense to the federal and state governments related to all unintended pregnancies and births. In addition, it serves to mitigate the spread of sexually transmitted diseases, and provides appropriate treatment for these diseases.

The Family PACT Program was implemented in January 1997. Originally a state-only program, Family PACT is currently funded through a federal Medicaid Family Demonstration Waiver which enabled substantial expansion of the program. The purpose behind the creation of this Waiver program by Congress was to allow states to develop innovative strategies, including systems to demonstrate new cost-effective ways of reducing unintended pregnancies and the resulting costs to Medicaid (Medi-Cal).

Under Family PACT, providers (private providers and clinics) assess a client's self-reported family size, income, need for confidentiality, and other eligibility criteria. If a client meets program criteria, the provider can enroll the client and provider services the same day. Eligibility data is transmitted to the state to review the information and make the final eligibility determination.

Family PACT is an extraordinarily successful program. It has been recognized nationwide for its positive impact on health outcomes and its cost-effectiveness in achieving its goals. It has been lauded in reducing unintended pregnancies.

Background—Family PACT Cost-Effectiveness. The federal government requires "budget neutrality" as a condition of approving any Medicaid Waiver. Budget neutrality means that the program must cost no more in federal financial participation than if the program did not exist and the target population instead utilized services through traditional Medicaid (Medi-Cal) programs. The federal CMS and federal Office of Management and Budget have concluded that California's Waiver has been budget neutral each of the five years of the program. **Based on the most recent year, the Family PACT saved \$2.46 for every dollar paid in federal financial participation.**

Subcommittee Staff Recommendation. *First*, it is recommended to approve the \$2.5 million (General Fund) to backfill for the loss of federal funds for these important services. These are important services that correspond to appropriate medical practices.

Second, it is recommended to have the DHCS keep the Subcommittee informed as negotiations with the federal CMS continue, and to have them provide an update at our May 7th hearing regarding any necessary next steps.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please clarify the Administration's agreement with the federal CMS as to the status of our Family PACT Waiver—i.e., how long can we continue to receive the month-to-month extensions?
2. DHCS, Please briefly describe the key federal CMS concerns and why their proposed changes would not be cost-beneficial to California.
3. DHCS, Please briefly describe the changes California will be making to Family PACT to address certain federal CMS concerns.
4. DHCS, What does the Administration anticipate the next steps to be in resolving these issues with the federal CMS?

6. AB 2911, Statutes of 2006--California Drug Discount Prescription Drug Program

Issue. The budget proposes to implement the CA Drug Discount Prescription Drug Program as enacted by Assembly Bill 2911 (Nunez), Statutes of 2006. Under the Administration's proposed implementation of this key legislation, the DHCS would conduct drug rebate negotiations, perform drug rebate collection and dispute resolution, and develop program policy, while a contractor would operate and manage the enrollment and claims processing functions.

Specifically, the budget proposes the following adjustments:

- Provides an increase of \$8.8 million (General Fund) to support 16 positions within the Department of Health Care Services (DHCS) to conduct various implementation functions and to support a \$6.8 million contract to design and implement the enrollment and claims processing functions. This General Fund increase is offset by a special fund appropriation as noted below
- Establishes a new item within the DHCS budget—Item 4260-006-001—which authorizes the State Controller to transfer up to \$8.8 million (General Fund) to the DHCS to support the CA Drug Discount Prescription Drug Program (i.e., it transfers General Fund into the new special fund referenced below). Budget Bill Language provides authority to the Department of Finance (DOF) to increase the amount of this transfer after providing a 30-day notification to the Legislature.
- Establishes a new item within the DHCS budget—Item 4260-001-8040 (CA Drug Discount Prescription Drug Program Fund)—which is a special fund to be used to track and appropriate all payments received under the program, including manufacturer drug rebates. This item assumes an appropriation of \$8.8 million which will be used to offset the General Fund expenditures for state support. The Administration is proposing trailer bill language to have this special fund be continuously appropriated and not subject to an annual appropriation through the Budget Act.

The DHCS states that considerable work needs to be completed for implementation. Pharmacists and management staff will need to develop policies related to outreach activities, participant enrollment, and drug rebate negotiation and collections. In addition, pharmacist staff will conduct rebate contract negotiations with drug manufacturers. The DHCS also notes that the program will require sophisticated legal analysis of complex issues, including manufacturer and pharmacy provider contracts, as well as addressing issues related to litigation. **Expenditures for the requested 16 staff positions would be \$2 million, including operating expenses.**

The positions include the following:

- Staff Manager III (to supervise the section);
- 6 Pharmacy-related positions, including recruitment and retention bonuses;
- Staff Counsel III;

- 4 Associate Governmental Program Analysts;
- 2 Senior Information Systems Analysts;
- Associate Administrative Analyst; and
- Executive Secretary

The budget also includes \$6.8 million for a contractor to design, develop and implement the client enrollment and claims reimbursement functions of the operations. The enabling legislation allows the DHCS to contract with a vendor for these aspects of the program. The DHCS intends to evaluate information from several vendors through a “request-for-information” (RFI) process. The DHCS will choose the vendor who can provide the highest quality product in the shortest timeframe. The enabling legislation also exempted the Administration from having to complete any normally required Feasibility Study Reports for information technology projects. The \$6.8 million amount is a reasonable estimate made by the DHCS based on similar past projects.

It should be noted that the volume of prescription drug dispensing will drive how much reimbursement from the CA Drug Discount Prescription Drug Program Fund will be necessary to cover pharmacy costs. A higher enrollment will result in a higher volume of prescription drug dispensing.

Drug rebates will be collected from the manufacturers on a quarterly basis and deposited into the CA Drug Discount Prescription Drug Program Fund for future payments to the pharmacies. Since the drug rebates will be collected in arrears, the funding necessary to pay pharmacies their portion of the prescription drug reimbursement not paid by the participant in the program, needs to be “floated” by the General Fund. The Item 4260-006-001 transfer, as referenced above, allows for this “float” (i.e., transfer between funds).

In addition, quarterly drug rebate collections to be done by the DHCS will lag behind the actual program expenditures by several months; therefore, additional funding must be available beyond the end of the fiscal year. As such, the Administration is proposing trailer bill language to allow for the CA Drug Discount Prescription Drug Program Fund to be continuously appropriated.

Overall Background—AB 2911 (Nunez), Statutes of 2006. This legislation created the CA Drug Discount Prescription Drug Program to address concerns regarding the lack of access to affordable prescription drugs by lower-income Californians. Recent information has shown that about 1.5 million people living in California needed a prescription drug but could not afford to buy it on their own.

The CA Drug Discount Prescription Drug Program is a drug discount program, not a benefit. The general structure of the program is for the state to negotiate with drug manufacturers and pharmacies for rebates and discounts to reduce prescription drug prices for uninsured and underinsured lower-income individuals.

Participation in the program is eligible to uninsured California residents with incomes below 300 percent of the federal poverty, individuals at or below the median family income with unreimbursed medical expenses equal to or greater than 10 percent of the family’s income,

share-of-cost Medi-Cal enrollees, and Medicare Part D enrollees that do not have Medicare coverage for a particular drug.

Enrollment in the program is to be simple and most likely will occur through local pharmacies. The only fees charged to individuals will be a \$10 enrollment fee for processing the initial program application and an annual \$10 re-enrollment fee. The legislation allows pharmacies and providers to keep the \$10 enrollment fee as payment for their assistance to enroll clients in the program.

Legislative Analyst's Office Recommendation—Approve 15 of 16 Positions. The LAO recommends deleting an Associate Governmental Program Analyst position. In addition, they recommend making a Staff Information Systems Analyst position a one-year limited-term position since the work would be one-time only in nature.

Subcommittee Staff Recommendation—Approve All 16 Positions. It is recommended to approve the entire package as proposed by the Administration, including the budget appropriation as well as the trailer bill legislation. This is a critical program that requires considerable work for implementation to occur by January 2008 as contained within the legislation.

Questions. The Subcommittee has requested the DHCS to respond to the following questions.

1. DHCS, Please provide a brief summary of how the program would operate overall and what the key operational issues are that need to be completed quickly.
2. DHCS, Please provide a brief summary of the specific budget request.

7. Proposed Reduction to Rates Paid to Pharmacists for Dispensing Drugs

Issue. The budget proposes a reduction of \$88 million (\$44 million General Fund) in Medi-Cal by changing the existing payment structure for pharmacy reimbursement from the “Average Wholesale Price” (AWP) to an “Average Manufacturer Price” (AMP) and by implementing the new “Federal Upper Payment Limit” (FUL). The proposed change requires trailer bill legislation to enact.

This proposed budget reduction assumes an effective date of August 1, 2007. However, it should be noted that the federal CMS has not yet issued federal regulations to standardize the manufacturer calculated AMP. Therefore this proposed budget reduction is a “ballpark” estimate until further direction from the federal CMS can be obtained.

The pharmacy reimbursement consists of two components—a drug ingredient cost and a dispensing fee. Generally, the drug ingredient cost constitutes about 85 percent of the payment per prescription to a pharmacy. The proposed reduction would reduce the amount paid for drug ingredient costs. The existing pharmacy dispensing fee is \$7.25 per prescription except for long-term care pharmacies which receive \$8.00 per prescription.

The department states that changes in the federal Deficit Reduction Act make the proposed reduction viable for the state since certain drug cost information will now be readily available for comparison purposes which they contend is consistent with federal requirements.

No adjustment to the dispensing fee is proposed by the department at this time. However, the department is presently using a contractor to conduct a study of Pharmacy dispensing fees. Unfortunately, this study will not be completed until late May. This makes it difficult for the Legislature to respond to any needs for a dispensing fee adjustment difficult within the budget timeline constraints. As noted below, the Legislature had provided funding for this study in the Budget Act of 2006 but it was vetoed by the Governor. Therefore the DHCS is having to redirect resources to conduct the study and has later timelines.

Background--Governor’s Veto of Legislature’s Augmentation for Study of Pharmacy Dispensing Fee. In anticipation of the likelihood that the federal DRA would affect the Medi-Cal Program, the Legislature provided \$600,000 (\$300,000 General Fund) in the Budget Bill of 2006 for the department to conduct an independent survey of Pharmacy dispensing fees. The last survey was completed in 2002 using data from 2000. Unfortunately, the Governor vetoed this augmentation and the accompanying language.

Background—Existing Medi-Cal Pharmacy Program. Under Medi-Cal, enrollees can obtain prescription drugs from any Pharmacy enrolled as a provider in the Medi-Cal Program. The Pharmacy in turn submits a reimbursement claim to Medi-Cal for the drug cost. This claim is processed through the Medi-Cal on-line claims adjudication system to verify it. The Pharmacy also receives a dispensing fee for each prescription.

Through the Budget Act of 2004, the reimbursement rate paid to Pharmacists under the Medi-Cal Program was changed. **The drug ingredient cost was changed to be “Average**

Wholesale Price” (AWP) minus 17 percent. The dispensing fee was increased from \$4.05 per prescription to \$7.25 per prescription except for long-term care pharmacies which receive \$8.00 per prescription.

Background—Federal Deficit Reduction Act of 2005 and Medicaid Pharmacy Changes. Among other things, the federal Deficit Reduction Act (DRA) made changes to the Medicaid (Medi-Cal) prescription drug program as it pertains to Pharmacy reimbursement. **The first change pertains to the “Average Manufacturer Price” (AMP).**

Prior to the DRA changes, the AMP was *solely* used by the federal government to calculate and determine the federal drug rebate. The AMP was calculated for each drug of a manufacturer and reported on a quarterly basis to the federal CMS. This *confidential* information was used to calculate federal drug rebates.

Under the DRA, drug manufacturers will have to abide by specific rules on the calculation of the AMP and will be required to report this information on a monthly basis, as well as on a quarterly basis. The federal CMS will use this information to calculate the federal drug rebates (as before) *and* to create new “federal upper limit” (FUL) prices. The AMP will now be public and will be provided to all state Medicaid programs.

The federal CMS has informed state Medicaid programs to use the monthly AMP information, when it becomes available, as well as retail price survey information to assess their pharmacy reimbursement rates, including the dispensing fees.

The second change pertains to the “federal upper limit” (FUL). The federal CMS establishes a FUL for generic drugs based on certain criteria. Prior to the DRA changes, a FUL price was calculated using price information obtained from pricing companies (such as First Data Bank) and was generally calculated based on three or more generically equivalent drugs on the market. The DRA changes how the FUL is calculated by requiring there to be only two generically equivalent drugs available on the market and by using the AMP in the calculation. **The affect of this change is that the FUL will decrease the reimbursement rate for generic drugs.**

Background—Existing Medi-Cal Contract Drug Program. California has historically had one of the least expensive Medicaid drug programs in the nation. Generally, Medi-Cal controls costs through two major components—a Medi-Cal List of Contract Drugs, and contracts with about 100 pharmaceutical manufacturers for state supplemental rebates. Drugs listed on the formulary are available without prior authorization.

In turn, the manufacturers agree to provide certain rebates mandated by both the federal and state government. The state supplemental rebates are negotiated by the department with manufacturers to provide additional drug rebates above the federal rebate levels.

Constituency Concerns. The Subcommittee is in receipt of constituency concerns from retail pharmacy representatives that the proposed changes would create a hardship on providers if the AMP reduction to the drug ingredient is enacted with no recognition of a need to increase the dispensing fee. They do not believe that the AMP is an accurate measure of drug costs and are very concerned that pharmacies will be hit with substantial cuts and will drop out of the Medi-Cal Program.

Subcommittee Staff Recommendation—Hold Open. *First*, it is recommended to encourage the DHCS to expedite their study on pharmacy dispensing fees and to provide it to the Subcommittee **as soon as it is completed**. It is very likely that the study will show a need to increase the portion of the reimbursement rate.

Second, it is recommended to hold this issue open pending the receipt of the Governor's May Revision. Additional information from the federal CMS may be available at this time, along with other pending details from the Administration.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. DHCS, Please briefly describe the existing pharmacy reimbursement process and how it would change under the budget proposal.
2. DHCS, When will the study regarding pharmacy dispensing fees be made available to the Subcommittee?
3. DHCS, When may further guidance from the federal CMS be available?

8. Request for Staff for Addressing Drug Rebate Disputes

Issue. The DHS is requesting an increase of \$1.1 million (\$542,000 General Fund) to fund eleven positions which are set to expire on June 30, 2007. The purpose of these positions is to collect on drug rebates owed to the state by drug manufacturers. These "aged" drug rebates are in dispute and must be reconciled through the department's system with the manufacturers.

The budget also reflects a savings of \$8 million (\$4 million General Fund) in local assistance which is attributable to the collection of the "aged" drug rebates.

Of the total eleven positions, 5.5 are proposed to be permanently established. These include 4.5 Associate Governmental Program Analysts and one Staff Services Manager I. The other 5.5 positions are proposed to be extended for one more year, until June 30, 2008. These include 4.5 Associate Governmental Program Analysts and one Staff Services Manager I.

These eleven positions were originally authorized in the Budget Act of 2003 on a three-year limited-term basis (until June 30, 2006). The Budget Act of 2006 continued the positions for another year (until June 30, 2007).

The dispute resolution process is complex and requires a high level of skill to operate the Rebate Accounting and Information System (RAIS) and the rebate-related software applications, and to learn the dispensing patterns of drugs. **As such, the DHS contends that continuation of existing staff is important to reduce the rebate backlog.**

Background—"Aged" Drug Rebates. Between 1991 and 2002, the Medi-Cal Program accumulated large rebate disputes with participating drug companies. The federal Office of Inspector General cited California in an audit that was published in 2002 due to these disputes. Originally over \$300 million in disputes were identified.

According to the department, about half of the disputes have been resolved and about \$49 million (\$24.5 million General Fund) has been collected to date. Another \$8 million (\$4 million General Fund) is estimated to be collected in the budget year.

Background—Why Do Rebate Payment Disputes Occur? According to the department, rebate payment disputes occur when the manufacturer is paying for fewer units than were invoiced by the department (i.e., manufacturer is paying less rebate to the state than calculated by the state). Disputes can be the result of human errors in the drug claiming and rebate processes on the part of pharmacies, manufacturers, and the federal CMS.

There are many reasons why manufacturers dispute their invoices. Examples of dispute reasons include: (1) pharmacies entering the incorrect dispensed quantity into the Medi-Cal claim system; (2) providers buying drugs that are exempt from rebate yet invoicing for full Medi-Cal price which erroneously includes them on the invoice; (3) providers billing the wrong unit of measure to which the rebate per unit is applied; and (4) manufacturers' challenging the state for legal reasons.

Legislative Analyst's Office Recommendation—Approve 5.5 Permanent Positions.

The LAO is recommending to approve 5.5 permanent positions, *and* to “hold open” pending the May Revision the remaining 5.5 limited-term positions.

The LAO contends that the 5.5 limited-term positions should be reviewed at the May Revision so that they can review whether any of these positions are vacant. If they are vacant, they would recommend deleting them since it takes about 9 months to train them. Therefore it is unlikely that new staff would be productive over the one year period for which the positions would be provided (i.e., extending them for one year until June 30, 2008).

Subcommittee Staff Recommendation—Modify Administration's Proposal.

Addressing the backlog of “aged” drug rebates, as well as new rebate amounts which may be disputed, has been an on-going issue for at least the past five years.

The Administration has made some headway by implementing the RAIS system and making improvements on the edits and cross-checks that the system conducts to mitigate disputes on the front-end of the process. However, state staff are also needed to conduct certain reconciliations of information and to keep abreast of drug manufacturers who owe rebate funds but are slow in paying the state.

The Administration and LAO both note that staff need to be intensively trained to be effective in their collection of the rebate funds, and that limited-term staff are difficult to hold onto due to the uncertainty of their position.

Therefore, it is recommended to provide an increase of 7 permanent Associate Governmental Program Analyst positions for a reduction of \$394,546 (\$197,273 General Fund). Providing permanent staff will mitigate the need for training new staff and conceivable, will increase productively as the existing staff continue with the work and become more knowledgeable regarding the nuisances of the rebate dispute process.

It should be noted that the DHCS also has 4 existing staff that provide assistance in this area as well.

Questions. The Subcommittee has requested the department to respond to the following questions.

1. DHCS, Please provide a brief description of the budget request and need for the positions.

9. Implementation of the federal Deficit Reduction Act: Medi-Cal Eligibility

Issue. The DHS is requesting an increase of \$571,000 (\$285,000 General Fund) to support 5 positions to implement various provisions of the federal Deficit Reduction Act of 2005 (DRA) that pertain to enrollment into the Medi-Cal Program. The requested positions include the following:

- Two Associate Governmental Program Analysts (permanent)
- One Associate Governmental Program Analyst (18-month limited-term to 12/30/2008);
- One Staff Counsel (one-year limited-term); and
- One Staff Counsel IV (supervising level) (18-month limited-term to 12/30/2008).

The DHS states three positions (i.e., two Associate Governmental Program Analysts and the Staff Counsel) would be used to work on implementing the DRA provisions relating to citizenship and identity.

The remaining two positions (i.e., a limited-term Associate Governmental Program Analyst and the Staff Counsel IV) would implement the DRA provisions relating to asset eligibility and the additional month of Medi-Cal eligibility for disabled SSI recipients under the age of 21.

Background—Deficit Reduction Act (DRA) of 2005. Among other things, the DRA made changes to the Medicaid Program (Medi-Cal) that deal with citizenship and identity documentation, asset eligibility, and disabled Supplemental Security Income (SSI).

The DRA changed eligibility requirements by requiring that any person who declares to be a citizen or national of the U.S. must now provide that documentation of citizenship and identity. People applying for Medi-Cal must provide that documentation before full scope Medi-Cal can be approved. If this documentation is not provided, Medi-Cal is limited to emergency and pregnancy related services. Enrollees that are now receiving Medi-Cal services who enrolled prior to the DRA changes must provide documentation at their next redetermination in order to receive full-scope continuing Medi-Cal services. This citizenship documentation requirement will affect over 4 million individuals enrolled in Medi-Cal.

With respect to asset eligibility, the DRA requires individuals who are requesting long-term care services or Waiver services will have to undergo an additional asset eligibility determination for payment of those services. Although these individuals may be eligible for Medi-Cal services of all other covered services, they may not be eligible to receive Medi-Cal-funded long-term care and Waiver services.

The asset eligibility changes also apply to individuals requesting services who, in the past, have received Medi-Cal automatically based on an eligibility determination made by the Social Security Administration for SSI/SSP or by CalWORKS.

In addition, the DRA also made changes regarding disabled children (less than 21 years). Specifically, the DRA requires states to provide Medicaid eligibility (Medi-Cal) in the month prior to the first month in which they receive the SSI payment. This change enables disabled children to enroll into Medi-Cal more quickly.

Legislative Analyst's Office Recommendation—Approve 3 of 5 Positions. The LAO recommends approving only three of the requested five positions for a savings of \$184,000 (\$91,500 General Fund). The Staff Counsel position and one Associate Governmental Program Analyst would be denied. The LAO states that much of the DRA work is one-time in nature and that the DHCS has already completed the bulk of the work.

In addition, the LAO also recommends making all of the three approved positions, including the Staff Counsel IV and two Associate Governmental Program Analysts, limited-term positions which would expire as of December 30, 2008.

Subcommittee Staff Recommendation—Modify Administration's Request. The federal DRA requirements are complex and will require DHCS staff work including legal analysis. **It is recommended to concur with the LAO to eliminate one of the Associate Governmental Program Analyst position but to retain the Staff Counsel position which is only an 18-month limited-term position anyway.**

Further, the requested Staff Counsel IV position is a supervising level position and would require Department of Personnel Administration approval before it could be filled. This level of position for an 18-month appointment seems excessive and most likely would be difficult to fill. Further, the DHCS has other legal staff who could handle this level of expertise if needed for the DRA implementation. **Therefore it is recommended to also down-grade the Staff Counsel IV position to a Staff Counsel position.**

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHS, Please provide a status update regarding the implementation of the DRA requirements.
2. DHS, Please provide a brief summary of the budget request.

10. Implementation of SB 1775, Statutes of 2006—Adult Day Health Care Changes

Issues. There are three budget year adjustments for this issue. Each of these issues is discussed below. *First*, the DHCS is requesting an increase of \$3.9 million (\$1.8 million General Fund) to fund 46 positions primarily to implement SB 1775 (Chesbro), Statutes of 2006 related to the Adult Day Health Care (ADHC) Program within Medi-Cal.

Second, the Department of Public Health (DPH) is requesting an increase of \$99,000 (\$49,000 General Fund) to fund an Associate Governmental Program Analyst in the Licensing and Certification Division of the DPH.

Third, the Medi-Cal local assistance budget assumes a reduction of \$5 million (\$2.5 million General Fund) by implementing more restrictive medical necessity criteria for enrollment into the ADHC Program effective as of January 1, 2008.

All of the requested 47 positions are outlined below by the area of designation.

- **DHCS Audits and Investigations (A&I) Branch—Total of 35 Positions.** A total of 35 positions are requested throughout this branch. The positions and their designated section within the branch are outlined below.

- ✓ **A&I Financial Audits Section—31 Positions.** This includes **(1)** 20 Health Program Auditor III's (three year limited-term); **(2)** 5 permanent Health Program Auditor III's; **(3)** 3 permanent Health Program Auditor IV's; **(4)** a permanent Health Program Audit Manager I; and **(5)** two Health Program Audit Manager I's (three-year limited-term).

These positions would primarily be used to audit 350 ADHC cost reports by no later than January 31, 2010 in order to allow for the analysis and calculation of rates that must take place before the rates can be applied to each of the 350 ADHC providers. The DHCS contends that staff needs to be hired and trained, and to commence with audits as soon as feasible. The three Health Program Audit Manager I's (one permanent with two being limited-term) would supervise the audit staff.

- ✓ **A&I Medical Review Section—2 Positions (permanent).** This includes a Medical Consultant I position and a Nurse Evaluator II position. These positions will focus on revisions to the medical necessity criteria and will assist in determining whether ADHC participants are receiving needed services.
- ✓ **A&I Investigations Section—2 Positions (permanent).** This includes two Fraud Investigator positions. These positions would be used to perform criminal investigations in cases where fraud and abuse are discovered. The investigators would work closely with the Department of Justice in prosecuting fraud cases that may result.

- DHCS Office of Legal Services—Total of 9 Positions. A total of 9 positions are requested throughout this branch. The positions and their designated section within the branch are outlined below.
 - ✓ Office of Legal Services, Office of Administrative Hearings and Appeals—4 Positions. These positions include: **(1)** an Administrative Law Judge; **(2)** a permanent Health Program Auditor IV; and **(3)** two Health Program Auditor IV's (three-year limited-term). The DHCS states that these positions will be needed to process appeals filed by ADHCs who are subject to the new audits.
 - ✓ Office of Legal Services, Administrative Litigation Section—4 Positions. These positions include: **(1)** two permanent Staff Counsels; **(2)** a Staff Counsel (three-year limited-term); and **(3)** a permanent Senior Legal Typist. The DHCS states that these positions will be needed to handle potential litigation from the upcoming changes.
 - ✓ Office of Legal Services, Medi-Cal House Counsel. The DHCS contends that medical reviews resulting from the ADHC Program will result in negotiated settlement agreements. This position would be used for this purpose, as well as to provide legal advice in all aspects of the development of regulations to be developed for the changes.
- DHCS Medi-Cal Program Area—Two Positions. First, an existing position would be converted to a Nurse Consultant III position to be used in the Medi-Cal Policy section to coordinate the implementation of reforms. Second, a permanent Research Analyst II position would be hired for the Rate Development section. This position would be used to carry out the workload associated with assisting in the development of a new rate reimbursement methodology.
- Department of Public Health, Licensing & Certification Division—1 Position. The budget includes a request for a permanent Associate Governmental Program Analyst position within the DPH's Licensing and Certification Division. This position would be used to update the current licensing regulations so they will conform to the reforms authorized in SB 1775.

The DHCS also assumes a reduction of \$5 million (\$2.5 million General Fund) in local assistance from implementing the medical necessity criteria as of January 1, 2008. The reduction level assumes the following:

- 30 percent of new users will not meet the revised medical eligibility criteria. This means that 362 individuals will not be eligible to enroll in ADHC services; and
- 15 percent of existing users will not meet the revised medical eligibility criteria. This means that 2,469 individuals will be terminated from ADHC services.

Background—Key Provisions of SB 1775 (Chesbro), Statutes of 2006. This legislation was crafted in response to federal CMS concerns with California's ADHC Program. Specifically, the federal CMS notified the DHS that certain specified changes needed to occur in the program in order for California to continue to receive federal matching funds. The state will be submitting a "State Plan Amendment" (SPA) to the federal CMS in 2009 that details the authorized reforms once implementation issues have been worked through.

SB 1755 authorizes the DHS to make major reforms to the ADHC Program over the next three years. As authorized by SB 1775, Statutes of 2006, the following significant reforms are to be instituted:

- Establish a set of definitions relating to ADHC services;
- Revise the standards for participant eligibility and medical necessity criteria in receiving ADHC services;
- Set forth new standards for the participant's personal health care provider and the ADHC center staff physician;
- Require the ADHCs to provide a set of core services to every participant every day of attendance; and
- Restructure the rate methodology to a prospective cost-based process requiring audited cost reporting.

The DHCS states that with the gradual implementation of SB 1755 reforms, it is estimated that beginning in 2011-2012 a savings of \$121.8 million (\$60.9 million General Fund) may be achieved. Savings leading up to 2011-2012 are expected to be limited. Savings are expected to stem from a combination of the following factors:

- Post-payment reviews with subsequent audit recoveries;
- Tightening of medical necessity criteria, eliminating authorization for Medi-Cal enrollees that do not require ADHC services to remain in the community;
- Unbundling of the ADHC all-inclusive procedure code and requiring ADHCs to bill only for those specific services provided that were medically necessary;
- Development of prospective costs reimbursement that tie the ADHC rates to the actual costs of providing the services; and
- Intensive and ongoing audits of ADHCs to prevent and resolve fraud and abuse issues.

Background—What Are Adult Day Health Care Services. Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic and social services designed to serve those at risk of being placed in a nursing home. The ADHC Program is funded in the Medi-Cal Program. The DHS performs licensing of the program and the Department of Aging administers the program and certifies each center for Medi-Cal reimbursement.

The baseline budget for the ADHC Program is \$375.8 million (\$187.9 million General Fund). The average monthly cost per ADHC user is \$931.11. The projected average monthly user of these services is 33,633.

The current reimbursement rate for ADHCs is 90 percent of the nursing facility level A rate. This is a bundled, all-inclusive rate for all ADHC services which was set by a court settlement in 1993. The budget assumes a 4.35 percent rate increase for these services as well which corresponds to existing law.

The bundled reimbursement rate pays for a day of ADHC services (defined as a minimum of four hours, not including transportation) regardless of the specified services actually provided on any given day. The bundled rate assumes that the required ADHC services will be provided to individuals as deemed medically necessary.

Background—Moratorium Continues on New ADHC. Through the Budget Act of 2004 and accompanying trailer bill legislation, a 12-month moratorium on the certification of new ADHCs became effective. This was done to diminish the growth of the centers due to concerns regarding rapid growth and the potential for Medi-Cal fraud, as well as concerns expressed by the federal CMS regarding the operation of California's program (which SB 1775, Statutes of 2006 address). With minor adjustments, this moratorium was extended for 2005 and 2006, and the budget assumes this continuation through 2007-08. Existing statute makes annual renewal of the moratorium the purview of the Director of Health Services (Director Sandra Shewry).

Legislative Analyst's Office Recommendation—Approve 33 of 46 Positions. The LAO recommends approving only 33 of the requested 46 positions for saving of \$1.370 million (\$685,000 General Fund).

The 13 denied positions include: (1) five Health Program Auditor III's; (2) five Health Program Auditor IV's (three from the Financial Audits Branch, two from the Office of Legal Services); (3) one Research Analyst II; and (4) two Staff Counsel positions (from the Administrative Litigation Section).

No issues have been raised regarding the reduction to local assistance of \$5 million (\$2.5 million General Fund).

Subcommittee Staff Recommendation—Adopt LAO Recommendation. The SB 1755 will be a significant effort and will require considerable work. However, the number of staff recommended by the LAO is still considerable and will take some time for the DHCS to hire and train. The DHCS can always request any necessary additional resources next year.

Further, the DHCS has considerable staff within the Audits and Investigations area and could, in certain cases, shift staff resources around to meet key priorities when necessary.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHCS, Please provide a brief summary of the key components of SB 1775 and describe the three proposed budget adjustments.

11. Proposed Trailer Bill—Enteral Nutrition Products & Medical Supplies

Issue (Hand Out). The Administration is proposing *broad* trailer bill language to more assertively pursue contracts for non-drug products offered under the Medi-Cal Program, including various medical supplies, incontinence supplies and enteral nutrition products.

The budget assumes a reduction of \$8.4 million (\$4.2 million General Fund) solely attributable to this proposed trailer bill language.

The DHCS states that they have expanded its management of the existing contracts for these non-drug products to include contracting for specific manufacturer products. They contend that this change mirrors the model set by the department's drug-contracting program. However, unlike drug contracting, state statute currently does not provide specific language that clarifies the process for these three categories (medical supplies, incontinence supplies and enteral nutrition products). The Administration further notes that this lack of specific authority has inhibited the DHCS from moving forward in some instances and has created disputes with manufacturers.

The language proposes a framework to the contracting process including criteria for product selection. At this time, it is *not clear* how this framework would be applied to the various products covered by the language.

Background—Medi-Cal Contracting (non-drug). The DHCS maintains the medical supply, enteral nutrition, and incontinence supply benefits that account for about \$240 million in total expenditures annually. Existing statute enables the DHCS to contract for these different products. These non-drug product contracts can either be a rebate contract or a guaranteed acquisition cost (i.e., guarantees a provider will not pay more than the contract amount to obtain the product) or a combination of both.

Subcommittee Staff Recommendation—Hold Open. The proposed language as presently crafted by the Administration is very broad and does not clearly provide appropriate patient protections that are often needed due to the number and diversity of special needs populations that the Medi-Cal Program serves. The medical supply area is a large category that covers hundreds of different and diverse products. As such, it is imperative to ensure that statute does not inadvertently limit access to special needs products.

In addition, the Administration has not yet actively engaged in discussions with constituency groups regarding the language and needs to do so soon.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHCS, Please provide a summary as to why the proposed trailer bill language is desired and specifically how it would function if implemented.
2. DHCS, How would unique patient needs be addressed under the language?

12. Continued Implementation of Health Insurance Portability & Accountability Act

Issue. The Administration is requesting an increase of \$2.4 million (\$582,000 General Fund) to fund 20 positions (19 of which are three-year limited-term) to continue the implementation of the federal Health Insurance Portability & Accountability Act (HIPAA). Of the requested increase, 19 of the positions (all three-year limited-term) are for the DHCS and one position is for the Department of Public Health.

Specifically, the 19 positions for the DHCS include the following by function area:

- **Management and Operational Support—4 Positions.** The DHCS states that these positions provide necessary management oversight and coordination. These positions include: a Staff Services Manager III (Branch Chief); a Senior Information Service Supervisor; and two Administrative Analysts.
- **Transaction Code Sets—6 Positions.** The DHCS states that these positions are needed to complete HIPAA code conversion efforts by 2010. The federal CMS is concerned about California completing this activity. The positions include: Dental Consultant; Medical Consultant; two Nurse Consultant III's; a Research Analyst II and a Staff Services Manager I.
- **Security—8 Positions.** The DHCS states that these positions are needed to address HIPAA security rules, including disaster recovery plans and security regarding Medi-Cal enrollee health information. The positions include: a Senior Information Systems Analyst; two Senior Information Systems Analysts; three Staff Information Systems Analysts; and two Associate Information Systems Analysts;
- **Privacy—2 Positions.** The DHCS states that two Associate Governmental Program Analyst positions are needed to address HIPAA rules regarding privacy concerns.

The Department of Public Health is requesting an Associate Governmental Program Analyst position (permanent) to continue HIPAA work for its programs that interact with the Medi-Cal Program.

Background on HIPAA. HIPAA, enacted in 1996, outlines a process to achieve national uniform health data standards and health information privacy in the U.S. It requires the adoption of standards by the federal Secretary of Health and Human Services to support the electronic exchange of a variety of administrative and financial health care transactions.

The federal government has published and continues to publish, multiple rules pertaining to the implementation of HIPAA. These rules will be published in waves and over the next several years. Among the standards are:

- Electronic transaction and data elements for health claims and equivalent encounter information, claims attachments, health care payment and remittance advice, health plan enrollment and disenrollment, health plan eligibility, health plan premium payments, first report of injury, health claim status and other items;

- Unique identifiers for individuals, employers, health plans and health care providers for use in the health care system;
- Code sets and classification systems for the data elements of the transactions identified; and
- Security and privacy standards for health information.

It should be noted that the CHHS Agency has an entire office--Office of HIPAA—that coordinates these issues with the various departments within the Health and Human Services Agency, and individual departments have staff sections which are responsible for day-to-day operations and HIPAA changes.

Legislative Analyst's Office Recommendation—Approve 11 of the Requested 19 Positions. The LAO recommends approving only 11 of the requested 19 positions for savings of \$858,000 (\$215,000 General Fund).

The 8 positions to be deleted include: **(1)** three Staff Information Systems Analysts; **(2)** two Associate Information Systems Analysts; and **(3)** three Associate Governmental Program Analysts. The LAO contends that the workload for one position is duplicative of a position requested to address new requirements for privacy and use of certain health care information. In addition, they note that the DHCS has a high vacancy rate for certain positions and that the department should fill these vacancies prior to requesting additional positions.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHCS, Please provide a brief summary of the budget request.

13. Proposed Trailer Bill Language—National Provider Identifier

Issue. The Administration is proposing trailer bill language to change state statute to conform to federal HIPAA requirements regarding provisions to establish the “National Provider Identifier” as the single identifier for health care providers who utilize HIPAA-covered electronic transactions (such as for Medi-Cal and Medicare).

This HIPAA rule requires that providers obtain a single provider number from the federal CMS and requires that only *one number* be used by that provider for *all* billings for all business locations. The DHCS states that implementation of this federal HIPAA rule is to be effective May 23, 2007. They contend that implementation of this rule without state statutory changes would place the DHCS at risk for litigation.

Implementation of this proposed trailer bill legislation would affect **all** Medi-Cal providers. All Medi-Cal providers would need to obtain a National Provider Identifier in order to receive Medi-Cal reimbursement. The DHCS states that this is necessary because without this requirement, the DHCS would have to maintain two separate databases—one using Medi-Cal provider numbers as required by state law and one for those providers who are required to use the National Provider Identifier under federal law.

Therefore, all Medi-Cal providers would need to obtain the identifier from the federal CMS. The DHCS will be working to make certain systems changes to the Medi-Cal reimbursement process in order to accept this identifier. At this time it is unclear as to when this will be completed, though it is to be soon. As such, Medi-Cal providers who do indeed already have a National Provider Identifier and use this to submit their reimbursement claims to the DHCS beginning as of May 23, 2007 as required by federal law, will have their claims rejected and will *not* get paid. These providers will need to resubmit their claims using their Medi-Cal provider number.

Background—National Provider Identifier. This rule under HIPAA establishes a national identifier for all providers that will be used to bill all payers, including Medi-Cal, Medicare, and private insurance. All DHCS programs must be assessed and remediated for their usage of the provider ID.

Subcommittee Staff Recommendation. *First*, it is recommended for the DHCS to keep the Subcommittee informed as to *any* issues that may come forth due to this comprehensive change and the anticipated concerns regarding provider reimbursement claims processing.

Second, it is recommended to adopt the Administration’s language as *placeholder* language in the event that any technical aspects need to be modified. If any substantive changes to this language are needed, Subcommittee staff will bring the issue back to the Subcommittee for discussion at the May Revision. However, it is unlikely that this will be necessary.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHCS, Please briefly describe how the National Provider Identifier is to work and when Medi-Cal will be ready to accept this identifier.
2. DHCS, What is being done to inform and work with Medi-Cal providers to ensure a less problematic transition?

14. Implementation of AB 1745, Statutes of 2006--Pediatric Palliative Care

Issue. The DHCS is requesting an increase of \$408,000 (\$174,000 General Fund) to fund three positions to implement AB 1745 (Chan), Statutes of 2006 regarding pediatric palliative care. The three positions include a Public Health Medical Officer III, a Research Analyst II, and a Health Program Specialist II.

Background—AB 1745 (Chan), Statutes of 2006. This legislation established the Nick Snow Children's Hospice and Palliative Care Act (Act) which allows eligible children and their families to receive palliative care services early in the course of the child's illness, while concurrently pursuing curative treatment for the child's condition.

Specifically, it requires the DHCS to develop and submit a Waiver to the federal CMS to conduct a Pilot to include services available through the existing Medi-Cal hospice benefit, and for the evaluation of the effectiveness of having a pediatric palliative care benefit for Medi-Cal enrollees aged 21 and under. The Pilot would combine both the medical, as well as special counseling and respite care services that are important for assisting the entire family.

Legislative Analyst Office Recommendation—Approve 2 of Requested 3 Positions. The LAO recommends approving only two of the requested three positions for savings of \$112,000 (\$56,000 General Fund). The LAO recommends deleting the Health Program Specialist II position.

Subcommittee Staff Recommendation—Approve 2 of Requested 3 Positions. It is recommended to approve only two of the requested three positions but to delete the Research Analyst II position, in lieu of the LAO's recommended Health Program Specialist II position. The work of the Research Specialist II pertains to evaluating expenditure data and monitoring outcomes. As such, this position could be deferred for a later date or some of the workload could be absorbed by the existing Medi-Cal Waiver research staff.

Questions. The Subcommittee has requested the DHS to respond to the following questions.

1. DHCS, Please provide a brief summary of the budget request.